



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

ANNUAL TRAINING DOCUMENTATION

DATE	TRAINING LENGTH
TRAINING LOCATION	
TRAINER NAME	TITLE / POSITION
TOPIC(S) PRESENTED: (CHECK ALL THAT APPLY.)	
<input type="checkbox"/> Meal Pattern Requirements*	<input type="checkbox"/> Daily Attendance Records
<input type="checkbox"/> Recordkeeping Requirements*	<input type="checkbox"/> Creditable Foods
<input type="checkbox"/> Meal Count Procedures*	<input type="checkbox"/> Child Nutrition
<input type="checkbox"/> Reimbursement System*	<input type="checkbox"/> Fostering Healthy Eating Habits
<input type="checkbox"/> Claim Submission & Review Procedures*	<input type="checkbox"/> Menus_____
<input type="checkbox"/> Infant Feeding (if applicable)	<input type="checkbox"/> Other_____
<input type="checkbox"/> Civil Rights Training	

Attendance Sign-In

Name (<i>signature</i>)	Print Name / Position

*REQUIRED TRAINING per Federal Regulation 7 CFR 226.15(e)(14)

*Training must include instruction, appropriate to the level of staff experience and duties, on Program requirements
Attach a copy of the training outline/lesson plan to this form.